Comments on Draft Frameworks

We appreciate the opportunity to comment on the draft frameworks related to consumer protections, long term care coordination and mental health and substance use and California's dual eligibles demonstration. We agree that the process for developing patient-centered, coordinated delivery models for dual eligibles that improve health, increase access to home and community based services and increase quality must be based on open dialogue and the transparent exchange of information. Providing draft principles like those contained in these documents is a positive step in that direction.

1. Consumer Protections

We agree that consumer protections must be included in the new integration models and were pleased to see that the framework adopts many of the principles advanced by advocates in the Request for Information responses. We note however, that there is less detail here than in the materials submitted by advocates in the past and are unsure whether this is because of space considerations or because the Department is not committed to some of those specifics.

In addition to the comments below, we would like to refer back to comments we submitted to the RFI and to our issue brief, "Ensuring Consumer Protections for Dual Eligibles in Integrated Models."

Comments on items in the framework:

- Beneficiary choice and control. We agree that beneficiary choice and control are key protections that must be present throughout the model. Beneficiaries must retain the right to:
    - Choose all of one's providers (including the right to hire, fire and manage their personal care worker);
    - Choose whether and how to participate in care coordination services;
    - Decide who will be part of a care coordination team;
    - Self direct care (with support necessary to do so effectively); and
    - Choose, ultimately, which services to receive and where to receive them.

  Choice begins with the opportunity to "opt-in" to integration demonstrations. An "opt-in" enrollment system honors the autonomy and independence of the individual by preserving for low-income dual eligibles the same right to

provider and delivery system choice that exists for middle and higher income Medicare beneficiaries. Preserving that choice is key to maintaining continued access to specialists and other providers that may not participate in the integrated model, particularly for those with complex medical conditions. Voluntary, "opt in" enrollment processes have been used by integration models that are generally regarded as positive, beneficiary-centered programs.

An "opt out" model is particularly problematic if applied to new, untested integration models. At their start, the ability of such models to deliver beneficiary-centered care coordination is unconfirmed. As models are implemented and thoroughly evaluated, it may be appropriate to consider more aggressive enrollment strategies.

Until then, an "opt in" enrollment system provides the best way to ensure that the new models grow into effective, beneficiary-centered programs. Other concerns that an "opt out" policy could address, such as adverse selection and marketing costs, can be addressed in other ways (for example, through appropriate rate setting, strict marketing rules and the use of independent enrollment brokers).

If an "opt-out" system is pursued, consumer protections will need to be developed around the enrollment process. Additional consumer protections will need to be added throughout the program, but especially regarding transitions, network adequacy and appeals. Furthermore, an "opt out" approach would require an even more careful and limited approach to selecting programs to participate in the demonstration.

- Beneficiary-centered models. We agree that these models must break from the traditional managed care, health insurance model and be built around the beneficiary, not the relationships and business model of a managed care plan.

- Comprehensive benefit design. We agree that models have the potential to integrate care and, if done carefully, realign incentives towards the provision of home and community based care. In addition to providing all Medicare and Medi-Cal services, we expect models to provide services above and beyond currently available benefits.

- Responsive appeals process. The demonstration should include an integrated appeals process that provides the best protections provided by the Medicare and Medicaid appeals processes. See our paper, "Building an Integrated Appeals System for Dual Eligibles" for more ideas on appeals.

- Transition rights to avoid care disruptions. Participants in the demonstration must be able to maintain relationships with existing providers.

- Meaningful notice. In addition to formal notices about rights and options, significant outreach will need to be done about the demonstrations and the impact they will have on how people receive care. This type of outreach takes time and should be incorporated into implementation timelines.

- Oversight and monitoring. Oversight mechanisms should be put into place that will allow the state and federal agencies to make corrections and address problems as they occur, not just after the fact. A program ombudsman should be considered. An ongoing role for stakeholders must be part of the oversight and monitoring.

- Phased approach. In addition to not expanding demonstrations statewide until they have been fully developed and evaluated for their effectiveness, the state should consider ways to phase the integration within the demonstrations. For example, plans that participate in the demonstration may be required to use existing entities and assessment tools during the early years of the project.

Comments on items not in the framework:

- Financing. How the demonstrations are financed will, ultimately, determine whether and how consumers are protected. We suggest a transparent discussion and process around how rates will be set and financial rewards and penalties structured. This subject may merit itsown framework and/or day-long meeting.

- Services, not just notices, must be culturally and linguistically appropriate and physically accessible.

- Network adequacy. An integrated model must provide adequate access to providers who are able to serve the unique needs of dual eligibles. In particular, measures of network adequacy need to take into account the high number of dual eligibles who have multiple chronic conditions, including dementia, who are very frail, who have disabilities, and who are limited English proficient. Integrated model networks must include appropriate ratios of primary care providers with training in geriatrics to the population to be enrolled, an adequate specialist network including a sufficient number of specialists in diseases and conditions affecting the dual eligible population

and a range of high quality nursing facility and home and community based provider options.

In addition to having expertise and being available for appointments, network providers must be prepared to provide special accommodations to dual eligibles. For example, the integrated model should enforce policies and payment structures that incorporate longer appointment times than are typically allocated for the general population. For many reasons—complex health conditions, limited English proficiency, disability, mental health condition—many members of this population require longer appointments if their needs are to be fully understood and appropriately addressed.

- Assessments. A concept should be added which recognizes the need for person-centered, standardized assessment tools which are capable of capturing accurately an individual's need for long term services and supports. Assessments need to be independent and conducted by professionals with experience assessing and providing LTSS.

2. Long-Term Care Coordination

The demonstrations must increase access to home and community based services and provide strong consumer protections to individuals in need of LTSS.

Comments on items in the framework:

- Consumer choice. The models must continue to provide consumers with the option to self-direct care and should provide the supports necessary for consumers to do so. Family members must continue to be eligible to be paid as providers of personal care services. Consumer choice also means involving the consumer in decision making about their care plan, providing the right to know what the options and resources are to make a better decision on what care arrangements best suit the individual's needs and preferences, and rights to appeal care decisions.
    - The first two bullets in this section of the draft framework do not seem related to consumer choice.

- Care coordination. Standards and policies related to care coordination are important, but those policies must allow consumers to choose whether to receive care coordination services and how to receive those services. They must have the option to decide who is a part of their care team and which information is shared within the team.
- Access to services. The demonstration must increase access to and

provision of home and community services to all individuals who need them. Services should be provided to those at risk of institutionalization and to others for whom the provision of services will help prevent them from becoming at risk. The demonstrations should be used as a tool for expanding, not restricting, the provision of needed services.

- Consumer as part of the coordinated care team. The consumer must have the right to be informed of and involved in care coordination activities and to make clear the consumer's own needs and desires. Consumers should also have the support and information necessary for them to serve as active and informed members of the team. Consumers should be provided the choice to lead their care team under a consumer-directed model.
    - Again, it's not clear that the sub-bullets relate to consumer involvement on care teams.

- Oversight and monitoring. In addition to aggressive monitoring by state and federal agencies, there must be easily accessible avenues for consumers to bring complaints or concerns to agencies overseeing the demonstration. Further, quality monitoring must be proactive, not just waiting for complaints or reviewing outcome measures.

- Workforce training. We agree with the principles laid out, but would add that the program design should respect the choice of a consumer to deny training for a worker or to choose an untrained worker out of a desire to maintain a less medicalized model for receiving long term supports and services.

Comments on items not in the framework:

- The title of this framework is "Long Term Care Coordination." It is unclear how coordination differs from integration. The Department should be clear with stakeholders about the difference between these two and should work with stakeholders to develop proposals that provide varying degrees of coordination and integration.

- The concepts in the framework make frequent reference to the medical benefit of providing LTSS. As a starting principle, all stakeholders must realize the value and importance of social supports and services and must be respectful of demands from consumers that the demonstration model not attempt to force these services into a 'medical model.'

- Many of the concepts allude to the desire to provide home and community based services to improve care and quality of life. We suggest making this a

separate concept that makes clear that one of the goals of the demonstrations is to increase access to home and community based services.

- As mentioned above, a concept should be added which recognizes the need for person-centered, standardized assessment tools which are capable of capturing accurately an individual's need for long term services and supports. Assessments need to be independent and conducted by professionals with experience assessing and providing LTSS.

3. Mental Health and Substance Abuse

We do not have specific suggestions for this section, but we do think the piece should note that the mental health and substance abuse services needs of older adults are under-diagnosed and undertreated and must be addressed.

Thank you for providing the opportunity to comment on these draft frameworks. Please contact Kevin Prindiville (kprindiville@nsclc.org) or Georgia Burke (gburke@nsclc.org) for more information about our comments.